MFTD Respite Referral Form

All fields are required unless marked "optional"

Please note that payment for all requested sessions are due on booking. This cost to families represents 7% of the total cost of providing respite care, with the rest subsidized by donations. Fees are necessary to secure the resources and commit to staffing. Assistance is available for families in need, please see our Resources page for more information.

GENERAL CONSENT

This request is being submitted with the knowledge and consent of names parents/legal guardians.
Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at: https://erinoakkids.ca/about-us/about-erinoakkids/accountability/policies/privacy-and-confidentiality

Consent Received: Yes No If No, ErinoakKids will not process this referral

ERINOAKKIDS' RESPITE SERVICES STREAMS

Please access the ErinoakKids website for descriptions and eligibility criteria for each respite service stream https://www.erinoakkids.ca/all-services/family-supports/respite-services

Medically Fragile Technologically Dependent (MFTD)

Please fill out the following four questions to determine eligibility for MFTD Respite Services:

Is your family member under the age of 18 years?

- ☐ Yes
- ☐ No *(if no, please fill out 18+ form)*

Does your family member reside in the Province of Ontario?

- ☐ Yes
- ☐ No *(If no, family member is not eligible for ErinoakKids Respite Services)*

Does your family member qualify for enhanced respite funding identified by Home and Care Community Support Services (HCCSS)? For additional information, please refer to https://www.healthcareathome.ca/

- ☐ I do not qualify *(family member is not eligible, please refer to Non-MFTD referral form)*
- ☐ I do qualify
- ☐ Unsure

Does your family member reside at home with their parent/caregiver?

- ☐ Yes
- ☐ No *(if no, family member is not eligible for ErinoakKids Respite Services)*

CLIENT INFORMATION

Date of Birth (dd-mmm-yyyy) ____________________

Gender Male Female Other

Child's Name

Last Name ____________________

First Name ____________________ Middle Name (optional) ____________________

Health Card # (optional) ________________Version Code ________________

Address

Unit#____________ Street# ____________Street Name ____________________

City ____________________ Postal Code ____________

Parent / Legal Guardian Names

1. Person to Notify *(primary contact - will be the only person notified for services)*

Last name ____________________ First Name ____________________

Relationship ____________________

Phone #1 ____________________ Phone Type ____________________

Phone #2 ____________________ Phone Type ____________________

Email ____________________

Address Same as client Different from Client *If different from client, please fill out below*

Unit#____________ Street#____________ Street name ____________________

City____________________ Postal Code ____________

2. Next of Kin *(secondary contact - optional)*

Last name ____________________ First Name ____________________

Relationship ____________________

Phone #1 ____________________ Phone Type____________________

Phone #2 ____________________ Phone Type____________________

Email ____________________

Address Same as client Different from Client *If different from client, please fill out below*

Unit#____________ Street#____________ Street name ____________________

City____________________ Postal Code ____________

Who your family member lives with:

☐ Both parents One parent Foster Parent

Other (specify) ____________________

Primary Language spoken in the home ____________________

Are Interpreter Services required? ☐Yes No Unsure If yes, state language/ASL ________________

SPECIAL NEEDS INFORMATION

Children's Protective Services, Agency Name: (optional) ____________________

Caseworker's Name (optional)________________Phone Number (optional) ________________

Diagnosis ☐Yes ☐No If yes, identify diagnosis ____________________

Identify area of concern: ____________________

Allergies ☐Yes ☐No If yes, specify allergy(s) ____________________

Epipen required? ☐Yes ☐No If yes, specify Epipen allergy____________________

DATE SELECTION

Please select your top 3 choices per quarter (three month period)

Medically Fragile Technologically Dependent (MFTD)

2025 Dates:

Quarter 4 (January - March 2025)

First choice: ______________________________

Second choice: ______________________________

Third choice: ______________________________

Quarter 1 (April -June 2025)

First choice: ______________________________

Second choice: ______________________________

Third choice: ______________________________

Thank for outlining your priority dates. We will work diligently to accommodate your dates as requested.

MEDICAL NEEDS

Does your family member use equipment or require respiratory support to help with their breathing in the day? Examples include tracheostomy, BiPap, CPAP, oral or trach suctioning, cough assist or oxygen.

Yes No If Yes, describe: ____

____

Which type of bed does your family member use? safety-enclosed bed (twin bed with 1-3 ft rails)
standard bed (twin bed with 6 inch rails)

BEHAVIOURAL NEEDS

Does your family member demonstrate any of the following

Does your family member demonstrate aggression towards others?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does your family member demonstrate aggression towards themselves?

- ☐ requires medical treatment
- ☐ requires first aid-treatment
- ☐ does not require treatment
- ☐ None of the above

Does your family member try to leave the house on their own?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

FUNDING

How will you be paying for your Respite stay?

☐Special Services at Home (SSAH) where ErinoakKids is your Transfer Payment Agency (TPA)
☐Parent Funded – self pay

REFERRAL SOURCE

Parent / Guardian   Medical   Community Agency   Other

Referral Source Name and Contact Information

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____
____

If you have any questions regarding your family member's eligibility, please contact our respite administration at (905) 855-2690 x2273

Thank you. Please submit the completed form.